



STATE OF NEW HAMPSHIRE
DEPARTMENT OF HEALTH AND HUMAN SERVICES
RADIOLOGICAL HEALTH SECTION
AUTHORIZED USER TRAINING AND EXPERIENCE
AND PRECEPTOR ATTESTATION

(For uses defined under New Hampshire Rules for the Control of Radiation
He-P 4035.41 & 4035.47)

Name of Proposed Authorized User:	State or Territory Where Licensed:
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Requested Authorization(s) – Check all that apply:

- | | |
|--------------------------------------------------------------------------|-----------------------------------------------------------------|
| <input type="checkbox"/> 4035.41 Manual brachytherapy sources | <input type="checkbox"/> 4035.41 Ophthalmic use of strontium-90 |
| <input type="checkbox"/> 4035.47 Gamma stereotactic radiosurgery unit(s) | <input type="checkbox"/> 4035.47 Remote afterloader unit(s) |
| <input type="checkbox"/> 4035.47 Teletherapy unit(s) | |

PART I – TRAINING AND EXPERIENCE
(He-P 4035.59, 4035.67 & 4035.69)

* Provide dates, duration, and description of training, continuing education, and experience related to the uses checked above and in accordance with He-P 4035.73.

☐ **1. Board Certification**

- a. Provide a copy of the board certification.
- b. For 4035.47, go to the table in 3.a. and describe training provider and dates of training for each type of use for which authorization is sought.
- c. Skip to and complete Part II Preceptor Attestation.

OR

☐ **2. Current 4035.47 Authorized User Requesting Additional Authorization for 4035.47 Use(s) Checked Above**

- a. Go to the table in section 3.a. to document training for new device.
- b. Skip to and complete Part II Preceptor Attestation.

OR

☐ **3. Training and Experience for Proposed Authorized User**

- a. For 4035.47, describe training provider and dates of training for each type of use for which authorization is sought.

Description of Training	Training Provider and Dates		
	Remote Afterloader	Teletherapy	Gamma Stereotactic Radiosurgery
Device operation			
Safety procedures for the device use			
Clinical use of the device			

Supervising Individual – If training was provided by Supervising Individual. (If more than one supervising individual is necessary to document supervised training, provide multiple copies of this page.)

License/Permit number listing supervising individual as an authorized user

Authorized for the following types of use:

- ☐ Remote afterloader unit(s) ☐ Teletherapy unit(s) ☐ Gamma stereotactic radiosurgery unit(s)

3. Training and Experience for Proposed Authorized User (continued)

b. Classroom and Laboratory Training ☐ 4035.59 ☐ 4035.67 ☐ 4035.69

Description of Training	Location of Training	Clock Hours	Dates of Training*
Radiation physics and instrumentation			
Radiation protection			
Mathematics pertaining to the use and measurement of radioactivity			
Radiation biology			

Total Hours of Training: _____

c. Supervised Work and Clinical Experience for 4035.59

☐ Remote afterloader unit(s) ☐ Teletherapy unit(s) ☐ Gamma stereotactic radiosurgery unit(s)

Total Hours of Experience: _____

Description of Experience Must Include	Location of Experience/ License or Permit Number of Facility	Confirm	Dates of Experience*
Reviewing full calibration measurements and periodic spot-checks		<input type="checkbox"/> Yes <input type="checkbox"/> No	
Preparing treatment plans and calculating treatment doses and times		<input type="checkbox"/> Yes <input type="checkbox"/> No	
Using administrative controls to prevent a medical event involving the use of byproduct material		<input type="checkbox"/> Yes <input type="checkbox"/> No	
Implementing emergency procedures to be followed in the event of the abnormal operation of the medical unit or console		<input type="checkbox"/> Yes <input type="checkbox"/> No	
Checking and using survey meters		<input type="checkbox"/> Yes <input type="checkbox"/> No	
Selecting the proper dose and how it is to be administered		<input type="checkbox"/> Yes <input type="checkbox"/> No	

Clinical experience in radiation oncology as part of an approved formal training program	Location of Experience/ License or Permit Number of Facility	Dates of Experience*
Approved by: <input type="checkbox"/> Residency Review Committee for Radiation Oncology of the ACGME <input type="checkbox"/> Royal College of Physicians and Surgeons of Canada <input type="checkbox"/> Committee on Postdoctoral Training of the American Osteopathic Association		
Supervising Individual	License/Permit number listing supervising individual as an authorized user	

3. Training and Experience for Proposed Authorized User (continued)

d. Supervised Clinical Case Experience 4035.67

Description of Experience	Location of Experience/License or Permit Number of Facility	Clock Hours	Dates of Experience*
Use of strontium-90 for ophthalmic treatment, including: Examination of each individual to be treated; Calculation of the dose to be administered; Administration of the dose; and Follow up and review of each individual's case history			
Supervising Individual		License/Permit number listing supervising individual as an authorized user	

e. Supervised Work and Clinical Experience for 4035.69

(If more than one supervising individual is necessary to document supervised work experience, provide multiple copies of this section.)

Total Hours of Experience: _____

Description of Experience Must Include	Location of Experience/License or Permit Number of Facility	Confirm	Dates of Experience*
Ordering, receiving, and unpacking radioactive materials safely and performing the related radiation surveys		<input type="checkbox"/> Yes <input type="checkbox"/> No	
Checking survey meters for proper operation		<input type="checkbox"/> Yes <input type="checkbox"/> No	
Preparing, implanting, and safely removing brachytherapy sources		<input type="checkbox"/> Yes <input type="checkbox"/> No	
Maintaining running inventories of material on hand		<input type="checkbox"/> Yes <input type="checkbox"/> No	
Using administrative controls to prevent a medical event involving the use of unsealed byproduct material		<input type="checkbox"/> Yes <input type="checkbox"/> No	
Using emergency procedures to control byproduct material		<input type="checkbox"/> Yes <input type="checkbox"/> No	

Clinical experience in radiation oncology as part of an approved formal training program	Location of Experience/License or Permit Number of Facility	Dates of Experience*
Approved by: <input type="checkbox"/> Residency Review Committee for Radiation Oncology of the ACGME <input type="checkbox"/> Royal College of Physicians and Surgeons of Canada <input type="checkbox"/> Committee on Postdoctoral Training of the American Osteopathic Association		
Supervising Individual	License/Permit number listing supervising individual as an authorized user	

f. Complete Part II Preceptor Attestation.

PART II – PRECEPTOR ATTESTATION

Note: This part must be completed by the individual's preceptor. The preceptor does not have to be the supervising individual as long as the preceptor provides, directs, or verifies training and experience required. If more than one preceptor is necessary to document experience, obtain a separate preceptor statement from each. (Not required to meet training requirements in 4035.68.)

By checking the boxes below, the preceptor is attesting that the individual has knowledge to fulfill the duties of the position sought and not attesting to the individual's "general clinical competency."

FIRST SECTION – Check one of the following for each requested authorization:

For 4035.59: ☐ **1. Board Certification**

I attest that _____ has satisfactorily completed the requirements in 4035.59(a).
Name of Proposed Authorized User

OR

☐ **2. Training and Experience**

I attest that _____ has satisfactorily completed the training
Name of Proposed Authorized User
and experience as required by 4035.59(b)(1), (b)(2) and (b)(3).

AND

I attest that _____ has received training required in 4035.59(c)
Name of Proposed Authorized User

for device operation, safety procedures, and clinical use for the type(s) of use for which authorization is sought, as checked below:

☐ Remote afterloader unit(s) ☐ Teletherapy unit(s) ☐ Gamma stereotactic radiosurgery unit(s)

For 4035.67: ☐ I attest that _____ has satisfactorily completed the training
Name of Proposed Authorized User

and experience as required by 4035.67(a)(2), and has achieved a level of competency sufficient to function independently as an authorized user of strontium-90 for ophthalmic use.

For 4035.69: ☐ **1. Board Certification**

I attest that _____ has satisfactorily completed the requirements
Name of Proposed Authorized User
in 4035.69(a)(1) and has achieved a level of competency sufficient to function independently as an authorized user of manual brachytherapy sources for the medical uses authorized under 4035.41.

OR

☐ **2. Training and Experience**

I attest that _____ has satisfactorily completed the training and
Name of Proposed Authorized User
experience as required by 4035.69(b), and has achieved a level of competency sufficient to function independently as an authorized user of manual brachytherapy sources for the medical uses authorized under 4035.41.

SECOND SECTION – Complete for all submittals.

☐ Remote afterloader unit(s) ☐ Teletherapy unit(s) ☐ Gamma stereotactic radiosurgery unit(s)

<input type="checkbox"/> 4035.41 Manual brachytherapy sources	<input type="checkbox"/> 4035.41 Ophthalmic use of strontium-90
<input type="checkbox"/> 4035.47 Remote afterloader unit(s)	<input type="checkbox"/> 4035.47 Teletherapy unit(s)
<input type="checkbox"/> 4035.47 Gamma stereotactic radiosurgery unit(s)	

Name of Preceptor:	Signature:	Telephone Number:	Date:
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License/Permit Number/Facility Name: